Integrated Care Demonstration Operations Plan Outline – 1/24/13 DRAFT
Model 2: Health Neighborhood (HN) – Client Enrollment, Care Coordination, & Rights

<mark>NOTE: In some places, text from the Demonstration application to CMS is presented as a starting point and for context, though some areas may be modified. **Areas in bold represent discussion of the small group of stakeholders convened by DSS, for further consideration by others, and will be the focus of the 1/25 Complex Care Committee meeting.** Additional conversations about other areas of this plan are ongoing.</mark>

Steps in joining an HN and receiving care coordination	Proposal
1. Initial analysis of data to inform outreach and enrollment:	
a. To determine which clients are linked to HNs: Data on client linkages to HN providers (and coordination with PCP/PCMH affiliation process)	From application to CMS: "MMEs who have received their primary care or behavioral health care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN under Model 2. The Department proposes to use a "step-wise" enrollment process under which the ASOs will: • first consider whether the individual has received care from a primary care provider (including a primary care physician, FQHC, clinic, or geriatrician), and if so, enroll on that basis; • if not, next consider whether the individual has received care from a behavioral health care provider (including psychiatrist, psychologist or licensed clinical social worker), and if so, enroll on that basis; and • if not, next consider whether the individual has received care from a specialist (including, but not limited to, a cardiologist or a nephrologist) for one or more chronic conditions, and if so, enroll on that basis." **[Note: care coordination stakeholders recommended also considering linkages with some other providers, for example, Medicaid waiver programs]**
b. "Risk level" of client	Note: Clients of all risk levels will be in the HN, but stratification will help to inform areas such as outreach and care coordination levels. Predictive modeling using data (a current capability of CHN) will be used for stratification, specifics TBD.
2. Enrollment in HN, and affiliation with Lead Care Manager (LCM): Based on HN provider links and risk levels:	Note: Specifics TBD regarding overlaps of some programs. For example, clients linked to an ACO or enrolled in a Medicare Advantage Plan can't also be enrolled in the Demonstration.
a. Information/outreach to members (initial and any ongoing)	From application to CMS: "MME participants of Model 2 will receive notice and a welcome packet from a neutral enrollment broker that they have been passively enrolled in an HN. The notice will disclose: • the benefits of participation, including, but not limited to access to the supplemental benefits

		that will be offered by HNs;
		
		• the nature of information sharing that will occur;
		• the nature of any shared savings agreement in which the HN is participating; and
		• the right to opt out of participation in the HN.
		
		The welcome packet will include such information as a list of provider membership in the HN, a list of qualified Lead Care Managers, and a description of how to access the supplemental benefits that will offered. Further, the welcome packet will include a form asking the MME to identify his or her preferred Lead Care Manager. The MME will be asked to return this form to the neutral enrollment broker, which will follow up with the MME at specified intervals should the MME not respond.
		
		  The Department will also partner with other recognized and trusted sources of information & assistance to educate participants on the benefits and obligations of Model 2. Examples of these include CHOICES (Connecticut's State Health Information Program), the Aging and Disability Resource Centers (ADRCs) and Infoline. **[Added note: Also see care coordination stakeholders' recommendations about potential HN provider roles]**
		
		  MME participants of Model 2 retain the right to opt out of participation in an HN in which they have been passively enrolled. If an MME chooses to opt out, he or she reverts to participation under Model 1. If MME participants of Model 2 wish to opt out of information sharing for purposes of the Demonstration, he or she reverts to participation under Model 1.
		
		  MME participants of Model 2 retain free choice of provider, regardless of whether a provider from which the MME wishes to receive service is participating in the HN."

b.	Enrollment will be on an opt-out basis. Need details of opt-out possibility (Including need to coordinate with data sharing opt-out process)	See row above for information.
c.	Opt-in possibility (How/when is HN offered to others? Would we affirmatively try to link people with no usual source of care to an HN?)	
d.	In what cases would a client enter or leave an HN after the initial roll-out?	
e.	Ask client to choose an LCM	**It was the sense of the group that all HN participants should be asked to identify an LCM. It was**

(what info on LCMs is made available? Who is asked to choose?)	**also the sense of the group that each HN should maintain and distribute a list of *entities* (as opposed to individuals) that are qualified to act as LCM.**

For clients who don't choose an LCM:
  i. Follow up outreach to promote choice of LCM, or to do screening, as appropriate? (by whom and when?)
  ii. Does anyone get a "default" assignment to an LCM? (when, using what criteria?)
	It was the sense of the group that entities with whom MMEs already have a trust basis (e.g. Medicaid waiver care coordinators, LMHA staff, etc.) should be enlisted in support of these activities.
	It was the sense of the group that individuals who are already working with a care manager (e.g. Medicaid waiver care coordinators, LMHA staff, etc.) should initially be "assigned" to that care manager and then given the option to either affirm that assignment or select another entity from the list of entities qualified to act as LCM. Members of the group commented that it will be important to try to avoid redundancy (too many actors trying to coordinate care) and to streamline care coordination services within families. It was suggested that a HN be asked how they would propose to reach out to those without an LCM in order to identify an LCM, and how they would propose to assign LCMs to any clients who do not choose one.

3. <u>Once a client is linked with a Lead Care Manager (LCM):</u>	
a. What are the LCM's responsibilities, qualifications, and training?	**The group affirmed CMS' preference that the LCM serve as the single point of contact (SPC) for all aspects (medical, behavioral health and long-term services and supports LTSS) and it seems that CMS's expectation is that a client has an individual person as an SPC (which would be determined within an LCM entity). The LCM's responsibilities will include supporting the enrollment process (details to be discussed), either performing a standard comprehensive assessment of the MME's needs and/or inventorying existing assessment information, and acting as a hub for communication and coordination among providers. There were differences of opinion about qualifications, with some in the group favoring the nurse care manager model, and others speaking in favor of the social work model. The group indicated that LCMs would ideally be licensed (for example, RN, LCSW). The group underscored the importance of having a team-based approach and using "extenders" (with both assessment and implementation of the care plan) as well as having standardized training for all LCMs (for example, through web-based modules).** (from application to CMS: "<u>Lead Care Manager</u>: For purposes of the Demonstration, a Lead Care Manager will be the identified single point of contact charged with assessing the need for, coordinating and ensuring provision of all needed Demonstration services. The Lead Care Manager must be an APRN, RN, LCSW, LMFT or LPC.")
b. How is screening or assessment	**It was the sense of the group that all duals demonstration participants should be subject of a**

done, what standardized tool is used, where is info captured, and with whom is it shared?	**standardized comprehensive assessment of needs, either by using the tool that will be developed for purposes of the demonstration (e.g. an expanded/tailored version of the CHN-CT tool) or by populating that tool with elements of already existing assessment results (e.g. Medicaid waiver assessment). It was the sense of the group that already existing assessment results could be utilized so long as the results are not more than six months old and no intervening life event (e.g. serious illness, hospitalization, bereavement, etc.) has occurred. It was the sense of the group that it is important for continuity and trust basis to have the same individual who has performed the assessment provide care management ongoing, though further discussion focused on the possibility that a team approach in which the person providing follow up differed from the one performing the assessment may be appropriate. Members of the group commented that it will be important to ensure that the tool assesses needs for social supports and that care coordination address end-of-life issues. Other aspects of this question have not yet been discussed.** ** Note that in the Balancing Incentive Program, care coordination must: a) utilize a no wrong door model; b) utilize a conflict free care coordination model; and c) utilize a standardized assessment tool.** From application to CMS: "All MMEs who are identified as in need of ICM, either through the predictive modeling approach described above or through self or provider referral, will be contacted by their identified Lead Care Managers to determine whether the MME wishes to participate in ICM. If the MME agrees, the Lead Care Manager will 1) conduct a comprehensive, in-person, home-based assessment of the MME's needs and preferences with the MME and his/her preferred representatives using an electronic care plan instrument and communication tools specifically adapted for this purpose; 2) identify any existing sources of care coordination (e.g. Medicaid HCBS waiver care coordinator, behavioral health care coordinator, Community Living Arrangement care coordination for individuals with intellectual disabilities, Money Follows the Person transition coordinators, dental ASO care coordinators, PCMH care coordinators); 3) prepare and request the MME's review and approval of a care plan; and 4) convene any and all relevant HN providers (including sources of care coordination) and sources of informal support (e.g. family caregivers, volunteers) in a multi-disciplinary, team-based approach to implementing the care plan. MMEs who are not identified as in need of ICM through predictive modeling may self-refer for this service, and/or may identify the need for assistance from their Lead Care Manager with care coordination activities including, but not limited to, referrals to medical, behavioral health, long-term services and supports and/or community-based services." **[Added note: Care coordination group discussed all clients receiving assessment, not just high risk]**

c. What are the standards for follow up and interactions, reassessment, etc?	**It was the sense of the group that a care plan review / assessment should take place at a minimum of every 6 months. Additionally, critical incidents (such as hospitalizations, ED use, identified gaps in care, etc.) should trigger outreach. A care plan would incorporate how often the plan should be reviewed. The group acknowledged that risk score as determined by predictive modeling from data and acuity as determined by LCM assessment might differ. See below for information on frequency of contact.**	

d. Other care coordination expectations and standards? (including all areas discussed within the white paper [see below]; also address care coordination protocols and data exchange between providers)
 	
Areas of focus from the care coordination white paper:
1. Care coordination format and intensity:
  a. Face-to-face contact
  b. Integration with and communication between providers
  c. Member to care coordinator ratios
  d. Nature of assessment
2. Electronic Health Records (EHRs) and communication of information
3. Member education and self-management
4. Focusing on transitions between care settings
5. Medication therapy management
6. Tailoring care coordination to specific populations
	• **It was the sense of the group that levels of intervention or intensity should be in levels. At points, those with more of a "crisis" or immediate need may need daily contact temporarily. The ratio of clients to MMEs would vary by risk level. The group was reluctant to be overly prescriptive and initially thought that each HN should propose these levels and frequency of interactions, but suggestions for starting points included:**

	Level 1: Basic	Level 2: Moderate	Level 3: Intensive
Care coordinator to member ratio	1: 70-80	1: 50-60	1: 30-40
Minimum ongoing contact	Monthly monitoring*	Monthly monitoring*, and one face-to-face contact every other month	Monthly face-to-face contact

* Monthly monitoring – includes contact with the client, family member, or a provider, can be telephonic or face-to-face. Perhaps can be performed by an extender.

• **Outreach to the client should be documented, even if the client declines to receive services at that point.**
• **The group discussed the role of the LCM as more of a broker and resource/referral manager who helps to decide who to pull in for treatment, as opposed to the LCM being a treatment provider. The group felt that the levels of service possible to provide would partially depend on the financial model.**
• **It was the sense of the group that each HN should be asked to identify what platform they would use for cross-provider communication**
• **The group discussed the importance of having the LCM empowered to drive the care plan, and all who participate in the HN affirming and agreeing to be responsive to the LCM.**
• **Regarding particular pieces such as self-management and self-education, it was the sense of the group that the program components should largely be developed and proposed by an HN. DSS should review for a robust program in these areas, which would meet specific basic**

	expectations, to be determined. DSS would like to develop more details.
4. Overall HN design questions (not specific to LCMs):	
a. Data sharing with HN and between members of HNs: HN/LCM enrollment, client's service utilization, care plans – what is shared with whom, and how? (Individual and/or population level utilization or care gap analyses performed?)	From application to CMS: "The ASOs will enable HN providers to access portals through which providers can view utilization data on their panels of MME patients."
b. Supplemental services: standards for them, how clients get access to them, how is utilization documented	See previously presented Leadership and Composition section of operating plan for more details on supplemental services. The LCM will refer and connect clients to supplemental services based on assessment and/or specific needs that arise.
c. For any client without an LCM on record: What services, assessments, or care coordination resources are available? Who is point of contact for any care coordination issues? (First need to choose LCM via enrollment broker?)	
d. Grievance processes and client rights at each step	From application to CMS: "…the Initiative will establish customer service standards for the medical and BH ASOs, HNs and clinicians/providers that will be providing education to and supporting the needs of participants… Once vetted, the standards will be published in the form of a statement of beneficiary rights and responsibilities and also will be incorporated within operational requirements for both the medical and BH ASOs and HNs… Beneficiary protections will include 1) strict adherence to existing statutory and State Plan requirements concerning beneficiaries' right of choice of provider; 2) right to participate in and to identify "next friend(s)" to join in participating in care planning; 3) right to receive care that is consistent with values and preferences; 4) statutory protections concerning rights of grievance, appeal and (Medicaid) fair hearing; 5) Health Insurance Portability and Accountability Act of 1996

	(HIPAA) rights concerning "protected health information" (PHI); 6) informed consent regarding release of PHI; 7) right of access to health records; 8) informed consent regarding participation in Intensive Care Management (ICM); 9) informed consent regarding participation in an HN, including disclosure of additional benefits of participation and financial incentives related to quality and cost; and 10) rights of accommodation, including, but not limited to, rights afforded by the Americans with Disabilities Act of 1990. Enhancements to these protections will include liaising with CMS to assess the viability of establishing a unified grievance and appeals system to streamline and universalize the process through which MMEs address such issues as eligibility determinations and re-determinations, limitations on or denials of approval for services and supports, and termination of eligibility… At a minimum, this could encompass: identifying an independent statewide Ombudsman entity through which grievances could be submitted; and using a standard appeals form that would initiate the process of appeal, irrespective of funding source, which could be internally tracked by the ASO or HN through either the DSS fair hearing process or Medicare appeals process, as applicable. The Department will require the ASOs to 1) inventory complaints, grievances and appeals; 2) detail responses/decisions; and 3) identify and address trends through staff training and member services protocols. The Department will also require the neutral enrollment vendor to track incidence of MMEs who are passively enrolled in Model 2 but opt out, and their reasons for doing so. Further, the Department will establish clear standards for such customer services aspects as 1) outreach and education materials to guide MMEs who are considering whether to remain in an HN; 2) roles of the ASO and HN, respectively, in responding to MMEs' care and services-related inquiries and requests for information and referral to clinicians or other providers; 3) means of providing language interpretation services; and 4) means of accommodating individuals with disabilities (e.g. TTY/TDD, accessible formats)… Finally, the Department will implement safeguards to ensure that MMEs receive necessary care in support of good health outcomes and a high quality of care experience. These safeguards will include 1) provider standards; 2) provider education through learning collaboratives; 3) population-specific studies of outcomes; and 4) audits. DDS and DMHAS plan to work with the Department to identify additional means of ensuring that individuals with intellectual disabilities or SMI do not face discrimination or differential treatment."